

09961  
377

10014

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Bradley St</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN EARL BAILEY</b>				4. DATE OF DEATH Month Day Year <b>SEPT. 22 ND 19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 11, 1886</b>	9. AGE (In years last birthday) <b>72 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee (Laborer) Marvel Package Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wicomico Co. Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John T. Bailey</b>				14. MOTHER'S MAIDEN NAME <b>Jennie Pollitt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mrs. Lula Bailey (Wife) Bradley St. Hebron, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral of Stroke</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>12 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>22 July, 19 57</b> , to <b>22 Sept, 19 57</b> , that I last saw the deceased alive on <b>20 Sept, 19 57</b> , and that death occurred at <b>8 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Md.</b> DATE SIGNED <b>9-23-57</b>						ACTUAL SIGNATURE <b>Earl L. Royer</b> M.D.	
PHYSICIAN'S NAME (Type) <b>Dr. Earl L. Royer</b>						ADDRESS <b>Salisbury Ave. Salisbury, Md.</b> <b>Sept 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 25, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hebron Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hebron Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24a. REC'D BY REGISTRAR <b>SEP 24 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary F. Holloway</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10015  
CERTIFICATE OF DEATH

09962

Reg. Dist. No. 332

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u>				c. LENGTH OF STAY IN 1b <u>70 Yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Main St.,</u>				d. STREET ADDRESS <u>1 Main St.,</u>			
3. NAME OF DECEASED (Type or print) First <u>NETTIE</u> Middle <u>BRADY</u> Last <u>BAILEY</u>				4. DATE OF DEATH Month <u>9</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 14, 1868</u>	
9. AGE (In years last birthday) yrs. <u>89</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Registered</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Osborne A.S. Brady</u>				14. MOTHER'S MAIDEN NAME <u>Annie Elizabeth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Wm. Brady of Quantico, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>?</u> <u>?</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Delmar, Maryland</u>				20g. (County) (State)			
21. I certify that I attended the deceased from <u>June 19, 1957</u> , to <u>Sept 23, 1957</u> , that I last saw the deceased alive on <u>June 19, 1957</u> , and that death occurred at <u>11:04 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Delmar, Maryland</u> DATE SIGNED <u>9/24/57</u> ACTUAL SIGNATURE <u>L.V. Sohler</u> M.D. PHYSICIAN'S NAME (Type) <u>Dr. L.V. Sohler 303 East St. Delmar, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Quantico Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Quantico, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson Co. Salisbury, Maryland</u>				24a. REC'D BY REGISTRAR <u>9-25-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	

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BUREAU V. S.

SEP 27 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9964 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09963

Reg. Dist. No. 33 ✓

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. Pen. Gen. Hospital</b>			d. STREET ADDRESS <b>418 W. College Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>LE ROY</b> Middle <b>JAMES</b> Last <b>BAYARD</b>			4. DATE OF DEATH Month <b>SEPT.</b> Day <b>1 st</b> Year <b>19 57</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 12, 1903</b>		9. AGE (In years last birthday) <b>54</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman - Employee Auto Company</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>William James Bayard</b>			14. MOTHER'S MAIDEN NAME <b>Henrietta Burris</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>217-10-2398</b>		17. INFORMANT <b>Mrs. Letty W. Bayard (Wife)</b> <b>Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 5, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>	
22d. LOCATION (City, town, or county) <b>Salisbury, Maryland</b>		22e. (State) <b>Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD</b>		ADDRESS <b>Salisbury, Maryland</b>		24a. REC'D BY REGISTRAR <b>SEP 6 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>					

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
001 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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SEP 6 1957  
BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9965 CERTIFICATE OF DEATH

Reg. Dis. No. 09964

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>		d. STREET ADDRESS <b>633 Truitt St</b>	
3. NAME OF DECEASED (Type or print) <b>OTH O</b>		4. DATE OF DEATH <b>SEPT. 1 st 19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 27, 1867</b>
9. AGE (In years lost birthday) <b>89</b> yrs.		IF UNDER 1 YEAR <b>11</b> Months <b>4</b> Days	IF UNDER 24 HRS. <b>Hours</b> <b>Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Light-House Keeper (U.S. Coast Guard)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Allen, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William John Bounds</b>		14. MOTHER'S MAIDEN NAME <b>Hastings</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Mattie V. Bounds (Wife)</b>		Address <b>633 Truitt St. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>446X</b> <b>Nephrosclerosis</b> DUE TO <b>10 days</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>10 days</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input checked="" type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 1957</b> to <b>Sept 1, 1957</b> , that I last saw the deceased alive on <b>Sept 1, 1957</b> , and that death occurred at <b>9:30 P M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William D. Gray</b>		DATE SIGNED <b>9/3/57</b>	
PHYSICIAN'S NAME (Type) <b>William D. Gray</b>		ADDRESS (Street, city or town, state) <b>Camden Ave. Salisbury, Md. Sept. 3 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept. 4, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Allen Meth Church Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Allen, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		24a. REC'D BY REGISTRAR <b>SEP 4 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary J. Holloway</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

LOCALITY OF DEATH		DATE OF DEATH	
COUNTY OF DEATH		TIME OF DEATH	
NAME OF DECEASED		AGE	
SEX		RACE	
MARRIAGE		EDUCATION	
OCCUPATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH	
IMMEDIATE CAUSE		MEDICAL HISTORY	
PREVIOUS ILLNESS		TREATMENT	
SIGNS AND SYMPTOMS		LABORATORY EXAMINATIONS	
POST-MORTEM EXAMINATION		PATHOLOGICAL FINDINGS	
TOPOGRAPHICAL HISTORY		SOCIAL HISTORY	
FAMILY HISTORY		PERSONAL HISTORY	
HISTORICAL DATA		PHYSICAL DATA	
MENTAL DATA		VITAL DATA	
GENERAL DATA		SPECIFIC DATA	
SUMMARY		REMARKS	

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SEP 5 1957  
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9966

CERTIFICATE OF DEATH

09965

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsular General Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>R.D. #3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>John</u> Middle <u>Wallace</u> Last <u>Brown</u>			<b>4. DATE OF DEATH</b> September 17-1957				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Colored</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>September 14-1957</u>	<b>9. AGE</b> (In years last birthday) yrs. <u>3</u>	<b>IF UNDER 1 YEAR</b> IF UNDER 24 HRS. Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>			
<b>13. FATHER'S NAME</b> <u>John Wallace Brown</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Frances Mae Harmon</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <u>John Wallace Brown - Father</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension</u> <u>774x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity (wt 1150 gram)</u> DUE TO (c)					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 Days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>	<b>(State)</b>		
<b>21. I certify that I attended the deceased from</b> <u>9/17</u> , 19 <u>57</u> , to <u>9/17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/17</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
<b>ACTUAL SIGNATURE</b> <u>Alfred C. Collins</u> M.D.			<b>DATE SIGNED</b> <u>Medical Center, Salisbury, Md</u>				
<b>PHYSICIAN'S NAME (Type)</b>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>22b. DATE THEREOF</b> <u>9/17/57</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Medela</u>	<b>22d. LOCATION (City, town, or county)</b> <u>Medela Springs</u>	<b>(State)</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John Wallace Brown</u>		<b>ADDRESS</b>	<b>24a. RECD BY REGISTRAR</b> DATE <u>SEP 20 1957</u>	<b>24b. REGISTRAR'S SIGNATURE</b> <u>Mary Holloway</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

02182191XV3

87

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of medical examiner		20. Signature of pathologist		21. Signature of anatomist	
22. Signature of histologist		23. Signature of bacteriologist		24. Signature of virologist	
25. Signature of parasitologist		26. Signature of immunologist		27. Signature of epidemiologist	
28. Signature of public health officer		29. Signature of health commissioner		30. Signature of governor	

RECEIVED  
SEP 20 1957  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09966  
Reg. Dist. No. 332

9967

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="float: right;">✓</span> <u>Delmar - Rural 462-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Near Mt. Nebo</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Harry</u> Middle <u>Eli</u> Last <u>Brown</u>				<b>4. DATE OF DEATH</b> Month <u>September</u> Day <u>27</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 25, 1902</u>	
9. AGE (In years last birthday) <u>54 yrs.</u>		IF UNDER 1 YEAR Months      Days      Hours      Min.		IF UNDER 24 HRS. Months      Days      Hours      Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Marvil Package Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joseph Brown</u>				14. MOTHER'S MAIDEN NAME <u>Estelle Neal</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-14-8267</u>		17. INFORMANT <u>Mrs. Edna F. Brown, Delmar, Del., R.F.D.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO (b) <u>Hypertension C. V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>year</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m.      19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>9-30-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 1, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Nebo Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Near Delmar, Delaware</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE 10-3-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH	
HISTORY OF PRESENT ILLNESS		PREVIOUS ILLNESSES		TREATMENT		HISTORY OF ALCOHOLIC DRINKING		HISTORY OF TOBACCO SMOKING		HISTORY OF DRUG USE	
FINDINGS AT AUTOPSY		LABORATORY EXAMINATIONS		TOXICOLOGY		BACTERIOLOGY		HISTOPATHOLOGY		OTHER FINDINGS	
SIGNATURE OF MEDICAL EXAMINER		DATE		PLACE		TITLE		HOSPITAL		CITY	

**BUREAU V. 3**  
 OCT 7 1957  
**RECEIVED**

1  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 9963  
 CERTIFICATE OF DEATH

09967

Reg. Dist. No.

332

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>7 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Deer's Head State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Bert</b> Middle <b>Byers</b> Last <b>Byers</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>7</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/3/1895</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Farm laborer</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John Byers</b>			
14. MOTHER'S MAIDEN NAME <b>Eliza Smith</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unk</b>				16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple sclerosis</b> <b>345X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gangrene of left leg due to arteriosclerosis obliterans</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <b>Oct. 18</b> , 19 <b>50</b> , to <b>Sept. 7</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Sept. 7</b> , 19 <b>57</b> , and that death occurred at <b>12:55</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>Dr. Juerman</b> M.D. <b>Deer's Head State Hospital</b> <b>9/7/57</b> PHYSICIAN'S NAME (Type) <b>V. Juerman, M. D.</b> <b>Salisbury, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/10/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bouldtown Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Centerville RFD. MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Washburn, Esq.</b>				24a. REC'D BY REGISTRAR <b>SEP 10 1957</b>			
24b. REGISTRAR'S SIGNATURE <b>Mary T. Holloway</b>							





9969

## CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>309 Oak St</b>				d. STREET ADDRESS <b>309 Oak St</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>HENRY</b> Last <b>CAMPBELL</b>				4. DATE OF DEATH Month <b>SEPT.</b> Day <b>11 th</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 8th, 1898</b>	
9. AGE (In years last birthday) <b>59</b>		IF UNDER 1 YEAR Months <b>59</b>		IF UNDER 24 HRS. Days <b>59</b>		Hours <b>59</b> Min. <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Live Stock Dealer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Live Stock</b>		11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Elizah Campbell</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Rittenhouse</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>Unk</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Mrs. Lydia M. Campbell (Wife)</b>				Address <b>304 Oak St. Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> <b>434.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>"Decompensation"</b> (c) <b>Chronic heart disease</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-10, 1957</b> , to <b>9-11, 1957</b> , that I last saw the deceased alive on <b>9-10, 1957</b> , and that death occurred at <b>1:00A M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dr. William B. Smith</b> M.D.				DATE SIGNED <b>Sept. 13/57</b>			
PHYSICIAN'S NAME (Type) <b>Dr. William Smith</b>				Medical Center Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 15th, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Walston, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24a. REC'D BY REGISTRAR <b>SEP 16 1957</b>			
24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

File No. 111

Place of death		Residence	
Hospital		Home	
Date of death		Date of birth	
Time of death		Time of birth	
Cause of death		Occupation	
Manner of death		Sex	
Race		Color	
Marital status		Education	
Religion		Social Security Number	
Signature of physician		Signature of registrar	
Signature of medical examiner		Signature of coroner	
Signature of funeral director		Signature of undertaker	
Signature of cemetery		Signature of burial place	
Signature of family		Signature of friends	
Signature of neighbors		Signature of community	
Signature of church		Signature of school	
Signature of other		Signature of other	

BUREAU V. E.  
SEP 16 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9970

## CERTIFICATE OF DEATH

09969

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>3 Mons.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1001 Riverside Dr.,</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EMMA NELL CHATHAM</b>				4. DATE OF DEATH <b>9</b> Month <b>16</b> Day <b>19</b> Year <b>57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 12, 1869</b>	
9. AGE (In years lost birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Issac James Harris</b>		14. MOTHER'S MAIDEN NAME <b>Sallie Ann Bounds</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Milton M. Bounds, Same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>prev. Cerebral Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO (c) <b>arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>10 yr.</b> <b>12 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>June 1956</b> to <b>Sept. 16, 1957</b> , that I last saw the deceased alive on <b>Sept. 16, 1957</b> , and that death occurred at <b>11:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>E.M. Beardsley</b> M.D.				ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b>			
DATE SIGNED <b>9/17/57</b>							
PHYSICIAN'S NAME (Type) <b>E.M. Beardsley 207 Maryland Ave., Salisbury, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/19/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Siloam Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Siloam, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hill &amp; Johnson Co. Salisbury, Maryland</b>				ADDRESS <b>Norman D. Baker</b>		24a. REC'D BY REGISTRAR <b>9-20-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary W. Hollaway</b>							

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		Male		45		1912		Baltimore		Maryland		United States			
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		HABIT		TENDENCY	
White		White		Roman Catholic		Married		High School		Carpenter		None		None	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		PREVIOUS ILLNESS		TREATMENT		POST-MORTEM	
September 23, 1957		Home		Heart Disease		Natural		Several Weeks		None		None		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF CHURCH		SIGNATURE OF OTHER	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

SEP 23 1957

BUREAU V. 1

RECEIVED





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.  
 CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
Cyrus G. Burdett		Male		45		1892	
Place of Birth		Race		Occupation		Cause of Death	
New York		White		Farmer		Heart Disease	
Residence		Marital Status		Date of Death		Time of Death	
New York		Married		1937		10:00 AM	
Physician		Funeral Home		Burial Place		Burial Date	
J. H. [illegible]		[illegible]		[illegible]		[illegible]	
Signature of Physician		Signature of Registrar		Signature of [illegible]		Signature of [illegible]	
[illegible]		[illegible]		[illegible]		[illegible]	

RECEIVED  
 JUN 30 1957  
 BUREAU V. I.  
 [illegible text at bottom]



10016

CERTIFICATE OF DEATH

09971330

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Powellville</b>		c. LENGTH OF STAY IN 1b <b>x2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# 2 Pittsville</b>		d. STREET ADDRESS <b>R.D.# 2 Pittsville</b>	
3. NAME OF DECEASED (Type or print) First <b>SADIE</b> Middle <b>WISE</b> Last <b>COLLINS</b>		4. DATE OF DEATH Month <b>SEPT.</b> Day <b>9</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 23, 1890</b>
9. AGE (In years lost birthday) <b>67</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Near Snow Hill, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>David Hales</b>		14. MOTHER'S MAIDEN NAME <b>Zipporah Gibbs</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Miss Edna E. Collins (Daughter)</b>		Address <b>R.D.# 2 Pittsville - Powellville, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>fulminating bilateral pneumonitis</b> DUE TO <b>204.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>492x</b> (b) <b>severe agranulocytosis</b> DUE TO <b>leukemic leukemia</b> (c) <b>3-4 mos.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>2 months</b> <b>3-4 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>splenomegaly severe</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 1955</b> to <b>Sept. 1957</b> , that I last saw the deceased alive on <b>Sept. 9, 1957</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert A. Grubb MD</b>		DATE SIGNED <b>9-10-57</b>	
PHYSICIAN'S NAME (Type) <b>ROBERT A. GRUBB, M.D.</b>		<b>Berlin, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 12, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Collins Family Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Whiton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		24a. REC'D BY REGISTRAR <b>SEP 16 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary J. Holloway</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		DATE OF BIRTH [Illegible]	
SEX [Illegible]		RACE [Illegible]	
MARRIAGE [Illegible]		EDUCATION [Illegible]	
OCCUPATION [Illegible]		RESIDENCE [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF REGISTRAR [Illegible]	
DATE OF SIGNATURE [Illegible]		DATE OF SIGNATURE [Illegible]	

RECEIVED  
SEP 16 1957  
BUREAU V. 3

9972

## CERTIFICATE OF DEATH

Reg. Dist. No.

09972

33

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>108 New York Ave</b>		d. STREET ADDRESS <b>108 New York Ave</b>	
3. NAME OF DECEASED (Type or print) First <b>NORMAN</b> Middle <b>WALLS</b> Last <b>CONNELLY</b>		4. DATE OF DEATH Month <b>SEPT.</b> Day <b>21</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 13th, 1892</b>
9. AGE (In years lost birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>3</b> Days <b>8</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Former Employee Wayne Pump Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Salisbury, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Hohn E. Connelly</b>		14. MOTHER'S MAIDEN NAME <b>Elenora Bradley</b>	
15. WAS DECEASED EVER IN U. S. ARMY FORCES? (If yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mrs. Marie B. Connelly (Wife)</b>		Address <b>108 New York Ave. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>420.1</b> DUE TO <b>Hypertensive atherosclerotic cardiac</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>vascular disease</b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b> <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Congestive Failure</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8/18/1956</b> to <b>9/10/1957</b> , that I last saw the deceased alive on <b>9/10/1957</b> , and that death occurred at <b>11:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>M.D. Maryland Ave.</b> DATE SIGNED <b>Sept. 23 1957</b>			
ACTUAL SIGNATURE <b>Dr. O.J. Burton</b>		PHYSICIAN'S NAME (Type) <b>Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept. 24, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, M.D.</b>		24a. REC'D BY REGISTRAR <b>Mary H. Holloway</b>	24b. REGISTRAR'S SIGNATURE <b></b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 24 1957



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9973

Item 12 Film G221 10-7-57 et

CERTIFICATE OF DEATH

09973

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>4366 Duboise Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>(MICHAEL)</u> Last <u>Diamond</u>		4. DATE OF DEATH <u>September 30-1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 17. 1912.</u>
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR: Months <u>11</u> Days <u>13</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Lawyer</u>	
11. BIRTHPLACE (State or foreign country) <u>Albania.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give date of service) <u>World War II</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Photios Pappas</u> Address <u>8301 Ferndale Ave Phila Pa</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Artery Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial Insufficiency; Bronchial Asthma; Cor pulmonale</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/29/</u> 19 <u>57</u> , to <u>9/30/</u> 19 <u>57</u> , that I last saw the deceased alive on <u>9/30/57</u> , 19 <u>57</u> , and that death occurred at <u>7:55</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D. <u>Salisbury Md</u>		DATE SIGNED <u>Sept. 30, 1957</u>	
PHYSICIAN'S NAME (Type) <u>Dr. David J. Gilmore</u>		Medical Center - Salisbury, Md. <u>Sept 30, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 1 / 57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fernwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Delaware Co. Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>GENEVIEVE A. VANSANT - 3027 N. 5th St. Phila. Pa.</u>		24. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	



CERTIFICATE OF DEATH

1. Name of deceased: *William L. ...*  
2. Date of death: *April 2, 1957*  
3. Place of death: *General Hospital*  
4. Cause of death: *Myocardial Infarction*  
5. Physician: *Dr. ...*

6. Burial place: *Greenwood Cemetery*  
7. Name of funeral home: *Greenwood Funeral Home*  
8. Signature of funeral home: *[Signature]*  
9. Date of burial: *April 5, 1957*

10. Registrar's signature: *[Signature]*  
11. Date of registration: *April 8, 1957*  
12. Registrar's name: *John A. ...*  
13. Office: *Bureau of Vital Statistics*  
14. Stamp: **RECEIVED**  
15. Stamp: **BUREAU V. S.**



9974

CERTIFICATE OF DEATH

09974

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Northtown, VA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>83X-3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Girl</u> First Middle Last <u>DOUGLAS</u>				4. DATE OF DEATH <u>SEPTEMBER 3</u> 19 <u>57</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 3, 1957</u>	
9. AGE (In years last birthday) yrs. <u>10</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>3</u>		IF UNDER 24 HRS. Hours <u>3</u> Min. <u>3</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Norman Douglas</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Norman Douglas</u> Address <u>Northtown, VA</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO (b) <u>Atelectasis</u> DUE TO (c) <u>Prematurity</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9.3.1957</u> to <u>9.3.1957</u> , that I last saw the deceased alive on <u>9.3.1957</u> , and that death occurred at <u>2:35</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J.S. Klotzer</u>				ADDRESS (Street, city or town, state) <u>Peninsula General Hospital, Salisbury, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>J.S. KLOTZER</u>				DATE SIGNED <u>9-9-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-5-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Talabane</u>		22d. LOCATION (City, town, or county) (State) <u>Northtown VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Whorton - New Church, VA</u>				24a. REC'D BY REGISTRAR <u>9-9-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary M. Holloway</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

Reg. No. 100

DECEASED

*John H. Smith*

*John H. Smith*

*John H. Smith*

*John H. Smith*

*John H. Smith*

*John H. Smith*

*John H. Smith*

BUREAU V. 1

SEP 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9975

## CERTIFICATE OF DEATH

Reg. Dist. No.

0997531

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> xo	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsular General Hospital</u>		d. STREET ADDRESS <u>R.D. #1</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Duncan</u> Last <u>Duncan</u>		4. DATE OF DEATH Month <u>September</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9 18 1908</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Fruitland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm. Duncan</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Christopher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-14-2303</u>	
17. INFORMANT <u>Florence Duncan</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> <u>610X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>P.C. Prostatic</u> (c) <u>Bump Prostate Hypertrophy</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/23/</u> 19 <u>57</u> , to <u>9/29/</u> 19 <u>57</u> , that I last saw the deceased alive on <u>9/29/</u> 19 <u>57</u> , and that death occurred at <u>2 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. A. Brielo</u> M.D.		DATE SIGNED <u>10.2.57</u>	
PHYSICIAN'S NAME (Type) <u>H. A. Brielo</u>		ADDRESS (Street, city or town, state) <u>Salisbury Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-4- 57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary</u>	22d. LOCATION (City, town, or county) (State) <u>Fruitland Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bookerm. West-</u> ADDRESS <u>Salisbury, Md</u>		24a. REC'D BY REGISTRAR <u>01 8 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

3, 5, 10, 20, 50, 100

Latitude - Longitude

10/10/93 2:10pm

1895

*(Faint handwritten notes)*

1911

BUREAU V. J.

OCT 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09976

9976

## CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>John B. Parsons Home</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>BESSIE</u> First Middle Last		4. DATE OF DEATH <u>8</u> Month <u>17</u> Day <u>1957</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 18, 1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Practical Nurse</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles A. Elliott</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Cannon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>John B. Parsons Home</u> Address <u>Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>164X</u> DUE TO <u>Excitation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Failure</u> (c) <u>Unapproved Ca of Medication</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/17/57</u> , 19 <u>57</u> , to <u>9/17/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/17/57</u> , 19 <u>57</u> , and that death occurred at <u>8:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. B. Smith</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>9/17/57</u>	
PHYSICIAN'S NAME (Type) <u>Dr. William B. Smith</u> <u>Medical Center, Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/20/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>First Methodist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Delmar, Delaware</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson Co.</u> ADDRESS <u>Salisbury, Maryland</u>		24a. REC'D BY REGISTRAR <u>9-20-57</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>			

BUREAU V. 8

SEP 23 1957

RECEIVED



9977

## CERTIFICATE OF DEATH

09977 338

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> 46X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>206 West 8th Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Andrew Fleetwood</u>				4. DATE OF DEATH Month Day Year <u>September 21 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 18 1890</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blouse Designer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Laurel R. Co. Delaware</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Dr. A. J. Fleetwood</u>				14. MOTHER'S MAIDEN NAME <u>Missie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>				16. SOCIAL SECURITY NO. <u>011-155X</u>			
17. INFORMANT <u>Mrs. Lauree Fleetwood Laurel Dela</u>				Address <u>Laurel Dela</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Ampulla of Vater</u> DUE TO (b) <u>67 mon</u> DUE TO (c) <u>67 mon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>67 mon</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7.16</u> , 19 <u>57</u> , to <u>9.21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9.26</u> , 19 <u>57</u> , and that death occurred at <u>9:25 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. A. Briele</u>				ADDRESS (Street, city or town, state) <u>Medical Center</u>			
PHYSICIAN'S NAME (Type) <u>H. A. Briele</u>				DATE SIGNED <u>9.21.57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10/3/1957</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Laurel Delaware</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas L. Lintan</u>				ADDRESS <u>Laurel Dela</u>			
24a. REC'D BY REGISTRAR <u>DATE</u>				24b. REGISTRAR'S SIGNATURE <u>Mary Holloman</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 24 1957

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

SEP 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9978 Item 11 Film G220 9-20-57 et  
CERTIFICATE OF DEATH

09978

Reg. Dist. No. 737

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springhill Sanitarium</b>		d. STREET ADDRESS <b>05X2.2</b>	
3. NAME OF DECEASED (Type or print) First <b>Nellie</b> Middle <b>Percy</b> Last <b>Fooks</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>9</b> Year <b>1957</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-16-1877</b>
9. AGE (In years last birthday) yrs. <b>79</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Laurel, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Dr. James Richard Phillips</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Elizabeth Percy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular renal disease</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-24</b> , 19 <b>57</b> , to <b>9-9</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>9-9</b> , 19 <b>57</b> , and that death occurred at <b>4:20 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Md.</b> DATE SIGNED <b>9-10-57</b>			
ACTUAL SIGNATURE <b>Philip A Insley</b>		M.D. <b>Salisbury, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Philip A Insley</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-12-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>East New Market</b>		22d. LOCATION (City, town, or county) (State) <b>E. New Market, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>St. M. Hall</b>		ADDRESS <b>Preston, Md.</b>	
24a. REC'D BY REGISTRAR <b>SEP 16 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary K. Holloway</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Maryland

Frederick

2 two weeks

22 January

Dr. J. H. Harrison

1906

1907

1908

White

Female

Honolulu

Dr. J. H. Harrison

Dr. J. H. Harrison

BUREAU V. S.  
SEP 16 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9979 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09979  
Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairmount</u> <u>19x2.2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>			d. STREET ADDRESS <u>Box 54</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert P Ford, Sr.</u>			4. DATE OF DEATH Month Day Year <u>9-16-57</u> <u>19</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 29, 1873</u>		9. AGE (in years last birthday) <u>84</u> rs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer &amp; Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>For Himself</u>		11. BIRTHPLACE (State or foreign country) <u>Fairmount, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			13. FATHER'S NAME <u>Charles T. Ford</u>		
14. MOTHER'S MAIDEN NAME <u>Mary Kimberly</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO.			17. INFORMANT Address <u>Robert P. Ford, Jr.—Camden, N. J.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u> <u>Years</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9-17-57</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 19, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mechanics Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Fairmount, Md.</u>		22e. (State) <u>Md.</u>		22f. (County)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bradshaw &amp; Sons--Crisfield, Maryland</u>		ADDRESS <u>Bradshaw &amp; Sons--Crisfield, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>9-20-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary W. Holliday</u>		24c. (State)			



RECEIVED

SEP 23 1957

BUREAU V. 2

9980

CERTIFICATE OF DEATH

09980 332  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>12</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>204 Isabella St</b>				d. STREET ADDRESS <b>204 Isabella St</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>MATELIDIA</b> Middle <b>ELIZABETH</b> Last <b>FOSKEY</b>				4. DATE OF DEATH Month <b>SEPT.</b> Day <b>2nd</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 9, 1883</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR: Months <b>2</b> Days <b>nd</b> Hours <b>19</b> Min. <b>57</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Sussex Co. Delaware</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>GEORGE Washington Wilkins</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Niblett</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mrs. Delema E. Holloway - 204 Isabella St. Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> <b>422.1</b> DUE TO <b>Severe generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic C-V Disease</b> (c) <b>Arteriosclerotic C-V Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>9/2</b> 19 <b>57</b> , to <b>9/5</b> 19 <b>57</b> , that I last saw the deceased alive on <b>9/2</b> 19 <b>57</b> , and that death occurred at <b>11:00 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William D. Gray</b> M.D.				ADDRESS (Street, city or town, state) <b>Salisbury, Md.</b> DATE SIGNED <b>9/5/57</b>			
PHYSICIAN'S NAME (Type) <b>Dr. William D. Gray</b>				334 Camden Ave. Salisbury, Md. <b>Sept. 5 /57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 6, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Melsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Delmar, Delaware</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24. REC'D BY REGISTRAR <b>SEP 6 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Mary K. Holloway</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. 3

SEP 6 1957

RECEIVED

9981

## CERTIFICATE OF DEATH

Reg. Dist. No.

09981337

1. PLACE OF DEATH o. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PEN. GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>WHALEYVILLE 23X2.2</u>			
3. NAME OF DECEASED (Type or print) First <u>NORMAN</u> Middle <u>GOWIE</u> Last <u>GOWIE</u>				4. DATE OF DEATH Month <u>SEPT.</u> Day <u>9</u> Year <u>19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 1918</u>		9. AGE (In years last birthday) <u>39 yrs</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF-EMPLOYED</u>		11. BIRTHPLACE (State or foreign country) <u>CAMDEN, N. J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM GOWIE</u>				14. MOTHER'S MAIDEN NAME <u>MARY WILLIAMS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>MRS. CHARLES HANCOCK PENNSVILLE N.J.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterior Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Arteriosclerotic Cardiovascular Dis</u> (c) <u>(?)</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/9</u> , 19 <u>57</u> , to <u>9/9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/9</u> , 19 <u>57</u> , and that death occurred at <u>P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Rufus S. Gardner, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>3215 Div. St. SALISBURY, Md.</u>		DATE SIGNED <u>9/9/57</u>	
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u> EGLINTON CEM</u>		22d. LOCATION (City, town, or county) (State) <u> CLARKSBORO N.J.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna P. Burbage</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR <u>SEP 11 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is mostly blank with some faint, illegible markings.

BUREAU V. S.

SEP 11 1957

RECEIVED



9982

## CERTIFICATE OF DEATH

Reg. Dist. No.

09982  
332

1. PLACE OF DEATH a. COUNTY <b>WILCOMICO</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>MARYLAND</b> <b>WILCOMICO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 SALISBURY</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PENINSULA GENERAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ALPINE HOLLOWELL Graham</b>				4. DATE OF DEATH Month Day Year <b>9 9 1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 23, 1867</b>	9. AGE (In years last birthday) <b>90</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>C. Wilson Hollowell</b>				14. MOTHER'S MAIDEN NAME <b>Alpine Bodine</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>MRS. Thomas Potts - SAME</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peripheral Circulatory Collapse</b> <b>570.2</b> DUE TO (b) <b>Mesenteric Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Generalized Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Old myocardial infarction and mild congestive failure</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>March</b> , 1956, to <b>Sept 9</b> , 1957, that I last saw the deceased alive on <b>Sept. 9</b> , 1957, and that death occurred at <b>9:30 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Thomas C. Hill, Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>224 N. Division Street Salisbury, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Thomas C. Hill, Jr.</b>				DATE SIGNED <b>Sept 10, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9/12/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>PARSONS CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>SALISBURY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Maryland</b> <b>Norman T. Baker</b>				24a. REC'D BY REGISTRAR <b>DATE 9-10-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
John Doe		Male		45		1-1-1912		1-15-1957		Home		Heart Disease		Natural		[Signature]		[Signature]	
11. Occupation		12. Education		13. Marital status		14. Usual residence		15. Usual place of work		16. Name of attending physician		17. Name of hospital		18. Name of funeral home		19. Name of undertaker		20. Name of cemetery	
Teacher		High School		Married		123 Main St		ABC Corp		Dr. Smith		St. Mary's		Doe & Sons		Doe & Sons		Greenwood	
21. Name of informant		22. Relationship to deceased		23. Informant's address		24. Informant's phone		25. Informant's occupation		26. Informant's signature		27. Informant's date		28. Informant's time		29. Informant's place		30. Informant's city	
Jane Doe		Wife		123 Main St		123-4567		Teacher		[Signature]		1-15-1957		10:00 AM		Home		Baltimore	

RECEIVED  
SEP 13 1957  
BUREAU V. 1

9983

## CERTIFICATE OF DEATH

Reg. Dist. No. 0998333

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BISHOP</u> 23X1-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsular General Hospital</u>				d. STREET ADDRESS <u>R.F.D.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>SEARUS</u> <u>Gray</u>				4. DATE OF DEATH Month Day Year <u>September 11</u> <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 20, 1899</u> 34 yrs.	
9. AGE (In years last birthday) <u>57</u>		10. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leander Gray</u>				14. MOTHER'S MAIDEN NAME <u>Nettie Jane Collins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>2184 16-6553</u>				17. INFORMANT Address <u>Mrs Edna Gray Bishop 3rd RFD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, Acute</u> <u>526X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchiectasis</u> DUE TO (c) <u>1 yr.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X Malnutrition</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 10, 1957</u> to <u>9-11-</u> 19 <u>57</u> , that I last saw the deceased alive on <u>9/11/57</u> , and that death occurred at <u>8:30</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Schure</u> M.D.				DATE SIGNED <u>Salisbury, Md. Sept. 11, 1957</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9/17/57</u>		<u>S.O.D.F.</u>		<u>Bishopville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peter Whaley Selby</u>				24a. REC'D BY REGISTRAR <u>SEP 13 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mary K. Holloway</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED: *WILLIAM J. HARRIS*  
 DATE OF DEATH: *SEP 10 1957*  
 PLACE OF DEATH: *HOME*  
 COUNTY: *ANNAPOLIS*  
 SEX: *MALE*  
 AGE: *78*  
 OCCUPATION: *RETIRED*  
 CAUSE OF DEATH: *HEART DISEASE*  
 MEDICAL HISTORY: *None*  
 SIGNATURE OF PHYSICIAN: *[Signature]*  
 SIGNATURE OF REGISTRAR: *[Signature]*

BUREAU V. 1

SEP 13 1957

RECEIVED

9984

CERTIFICATE OF DEATH

Reg. Dist. No. 09984 33✓

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>				d. STREET ADDRESS <b>1 Jersey Rd.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>LILLIAN</b> Middle <b>IRENE</b> Last <b>GUTHRIE</b>				4. DATE OF DEATH Month <b>SEPT.</b> Day <b>1 st</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 29, 1918</b>		9. AGE (In years last birthday) <b>39</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>1</b> Days <b>2</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee of Poultry Co. Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Lynhurst Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>G. W. Anderson</b>				14. MOTHER'S MAIDEN NAME <b>Ethel May Lotts</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Mr. Harry J. Guthrie (Husband) Jersey Rd. Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>175x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Original site Ovary</b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April, 1957</b> to <b>Sept 1, 1957</b> , that I last saw the deceased alive on <b>9-1</b> , 1957, and that death occurred at <b>7:15 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Wm B. Smith</b>				ADDRESS (Street, city or town, state) <b>Med. Center Sby Md</b> DATE SIGNED <b>9/2/57</b>			
PHYSICIAN'S NAME (Type) <b>Dr. William Smith</b>				<b>Salisbury, Md.</b> <b>Sept. 3/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 5, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24. REGISTRY BY REGISTRAR <b>SEP 4 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Mary A. Holloway</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09985

9985

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Alexandria</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>30 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>2100 Mt. Vernon Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u> Evelyn A </u> First Middle Last		4. DATE OF DEATH <u>September 16</u> 19 <u>57</u> Month Day Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 22, 1914</u> 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis Heironomus</u>		14. MOTHER'S MAIDEN NAME <u>Marion Wall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MR. JAMES HARDING, Son</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/15</u> , 19 <u>57</u> , to <u>9/16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/16</u> , 19 <u>57</u> , and that death occurred at <u>12:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William R. Ellis, Jr.</u> M.D. <u>SALISBURY, MARYLAND</u>		DATE SIGNED <u>9/16/57</u>	
PHYSICIAN'S NAME (Type) <u>WILBER R. ELLIS, JR.</u>		MEDICAL CENTER, <u>SALISBURY, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 18, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Uwy Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Alexandria Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. H. Demaine Jr.</u> ADDRESS <u>Alex. Va.</u>		24a. REC'D BY REGISTRAR <u>SEP 20 1957</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

STATE OF MARYLAND—BALTIMORE 19

SEP 20 1957

RECEIVED

10017

CERTIFICATE OF DEATH

Reg. Dist. No.

09986  
09986

332

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parsonsborg</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>In Village - at Home</b>				d. STREET ADDRESS <b>at Home</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>GEORGE</b> First <b>HUTCHISON</b> Middle <b>Sept.</b> Last <b>5 th</b> 19 <b>57</b> Year				4. DATE OF DEATH			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 5, 1893</b>	
9. AGE (In years lost birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR <b>7</b> Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk-Service Station Attendent-Clerking</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>London, England</b>		11. BIRTHPLACE (State or foreign country) <b>ENGLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>ENGLAND</b>							
13. FATHER'S NAME <b>Thomas Crosby Hutchison</b>				14. MOTHER'S MAIDEN NAME <b>Jane - - - - - (unk)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No - (English Army W.W.I)</b>				16. SOCIAL SECURITY NO. <b>214-10-8146</b>		17. INFORMANT <b>Mrs. Beatrice Maude Hutchison (Wife)</b> Address <b>Parsonsborg, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420.1 DUE TO <b>Coronary atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Angina pectoris</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Angina pectoris</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour o. m. <b>3</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Sept 5</b> to <b>Sept 5</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Sept 5</b> , 19 <b>57</b> , and that death occurred at <b>3:00 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Earl M. Beardsley</b>				DATE SIGNED <b>Sept. 6 / 57</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Earl Beardsley</b>				ADDRESS <b>Maryland Ave. Salisbury, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 7, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsonsborg Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Parsonsborg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24. REC'D BY REGISTRAR <b>SEP 9 1957</b>			
				24b. REGISTRAR'S SIGNATURE <b>Mary St. Holloway</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF DEATH [Illegible]		5. TIME OF DEATH [Illegible]		6. PLACE OF DEATH [Illegible]	
7. CAUSE OF DEATH [Illegible]		8. MANNER OF DEATH [Illegible]		9. PLACE OF BIRTH [Illegible]	
10. OCCUPATION [Illegible]		11. EDUCATION [Illegible]		12. MARITAL STATUS [Illegible]	
13. PREVIOUS ILLNESS [Illegible]		14. PREVIOUS SURGERY [Illegible]		15. PREVIOUS TRAUMA [Illegible]	
16. PREVIOUS DRUGS [Illegible]		17. PREVIOUS ALCOHOL [Illegible]		18. PREVIOUS TOBACCO [Illegible]	
19. PREVIOUS RADIATION [Illegible]		20. PREVIOUS CHEMICALS [Illegible]		21. PREVIOUS OTHER [Illegible]	
22. PREVIOUS INJURY [Illegible]		23. PREVIOUS DISEASE [Illegible]		24. PREVIOUS TRAUMA [Illegible]	
25. PREVIOUS SURGERY [Illegible]		26. PREVIOUS TRAUMA [Illegible]		27. PREVIOUS DISEASE [Illegible]	
28. PREVIOUS INJURY [Illegible]		29. PREVIOUS DISEASE [Illegible]		30. PREVIOUS TRAUMA [Illegible]	
31. PREVIOUS SURGERY [Illegible]		32. PREVIOUS TRAUMA [Illegible]		33. PREVIOUS DISEASE [Illegible]	
34. PREVIOUS INJURY [Illegible]		35. PREVIOUS DISEASE [Illegible]		36. PREVIOUS TRAUMA [Illegible]	
37. PREVIOUS SURGERY [Illegible]		38. PREVIOUS TRAUMA [Illegible]		39. PREVIOUS DISEASE [Illegible]	
40. PREVIOUS INJURY [Illegible]		41. PREVIOUS DISEASE [Illegible]		42. PREVIOUS TRAUMA [Illegible]	
43. PREVIOUS SURGERY [Illegible]		44. PREVIOUS TRAUMA [Illegible]		45. PREVIOUS DISEASE [Illegible]	
46. PREVIOUS INJURY [Illegible]		47. PREVIOUS DISEASE [Illegible]		48. PREVIOUS TRAUMA [Illegible]	
49. PREVIOUS SURGERY [Illegible]		50. PREVIOUS TRAUMA [Illegible]		51. PREVIOUS DISEASE [Illegible]	
52. PREVIOUS INJURY [Illegible]		53. PREVIOUS DISEASE [Illegible]		54. PREVIOUS TRAUMA [Illegible]	
55. PREVIOUS SURGERY [Illegible]		56. PREVIOUS TRAUMA [Illegible]		57. PREVIOUS DISEASE [Illegible]	
58. PREVIOUS INJURY [Illegible]		59. PREVIOUS DISEASE [Illegible]		60. PREVIOUS TRAUMA [Illegible]	
61. PREVIOUS SURGERY [Illegible]		62. PREVIOUS TRAUMA [Illegible]		63. PREVIOUS DISEASE [Illegible]	
64. PREVIOUS INJURY [Illegible]		65. PREVIOUS DISEASE [Illegible]		66. PREVIOUS TRAUMA [Illegible]	
67. PREVIOUS SURGERY [Illegible]		68. PREVIOUS TRAUMA [Illegible]		69. PREVIOUS DISEASE [Illegible]	
70. PREVIOUS INJURY [Illegible]		71. PREVIOUS DISEASE [Illegible]		72. PREVIOUS TRAUMA [Illegible]	
73. PREVIOUS SURGERY [Illegible]		74. PREVIOUS TRAUMA [Illegible]		75. PREVIOUS DISEASE [Illegible]	
76. PREVIOUS INJURY [Illegible]		77. PREVIOUS DISEASE [Illegible]		78. PREVIOUS TRAUMA [Illegible]	
79. PREVIOUS SURGERY [Illegible]		80. PREVIOUS TRAUMA [Illegible]		81. PREVIOUS DISEASE [Illegible]	
82. PREVIOUS INJURY [Illegible]		83. PREVIOUS DISEASE [Illegible]		84. PREVIOUS TRAUMA [Illegible]	
85. PREVIOUS SURGERY [Illegible]		86. PREVIOUS TRAUMA [Illegible]		87. PREVIOUS DISEASE [Illegible]	
88. PREVIOUS INJURY [Illegible]		89. PREVIOUS DISEASE [Illegible]		90. PREVIOUS TRAUMA [Illegible]	
91. PREVIOUS SURGERY [Illegible]		92. PREVIOUS TRAUMA [Illegible]		93. PREVIOUS DISEASE [Illegible]	
94. PREVIOUS INJURY [Illegible]		95. PREVIOUS DISEASE [Illegible]		96. PREVIOUS TRAUMA [Illegible]	
97. PREVIOUS SURGERY [Illegible]		98. PREVIOUS TRAUMA [Illegible]		99. PREVIOUS DISEASE [Illegible]	
100. PREVIOUS INJURY [Illegible]		101. PREVIOUS DISEASE [Illegible]		102. PREVIOUS TRAUMA [Illegible]	

RECEIVED  
SEP 9 1957  
BUREAU V. 3

CHIEF OF BUREAU  
STATE DEPARTMENT OF HEALTH  
BALTIMORE, MARYLAND



9986

## CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY 12</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>913 Johnson ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>Russell</u> Middle <u>Kerley</u> Last <u>JR.</u>				4. DATE OF DEATH Month <u>September</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-16-1926</u>	9. AGE (In years last birthday) <u>30</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ELECTRIC CO</u>		11. BIRTHPLACE (State or foreign country) <u>DELMAR MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>RUSSELL KERLEY SR</u>				14. MOTHER'S MAIDEN NAME <u>PEARL TINGLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>215-20-2180</u>		17. INFORMANT Address <u>ELLEN KERLEY-SALISBURY MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute myocardial infarction</u> DUE TO (b) <u>Arteriosclerotic vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>9/27/1957</u> to <u>9/27/1957</u> , that I last saw the deceased alive on <u>9/27/1957</u> , and that death occurred at <u>9:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
PHYSICIAN'S NAME (Type) <u>O. J. BURTON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-30-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MELSON</u>		22d. LOCATION (City, town, or county) (State) <u>DELMAR MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Delmar</u>				24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>Mary T. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 1 1957

1 OCT 1 1957

RECEIVED

9987

## CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>105 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Gilbert</b> Middle <b>Landon</b> Last <b>Landon</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>2</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/11/1892</b>	9. AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months <b>6</b> Days <b>4</b> Hours <b>0</b> Min.	IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Princess Anne</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Landon</b>				14. MOTHER'S MAIDEN NAME <b>Carrie Coveridal</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Unk.</b> (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Hospital Records</b> Address <b>-</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recurrent cerebral thrombosis</b> <b>332x</b> DUE TO <b>Arteriosclerosis, general</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>?</b> DUE TO (c) <b>?</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Residual right hemiplegia</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b>		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 20</b> , 19 <b>57</b> , to <b>Sept. 2</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Sept. 2</b> , 19 <b>57</b> , and that death occurred at <b>9:45 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dr. V. Juerman</b>				ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>9/3/57</b>			
PHYSICIAN'S NAME (Type) <b>Dr. V. Juerman</b>				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/7/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>John Wesley</b>		22d. LOCATION (City, town, or county) (State) <b>College Grove md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William H. James Jr.</b> ADDRESS <b>Princess Anne md.</b>				24a. REC'D BY REGISTRAR <b>9-6-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary W. Holloray</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

9988

## CERTIFICATE OF DEATH

Reg. Dist. No.

09988237

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY in 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Penninsula General Hospital</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SNOW HILL 28x1.2</u>			
				d. STREET ADDRESS <u>R.F.D. #2</u>			
				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Joseph C. Lankford</u>				4. DATE OF DEATH <u>September 17 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 20 1911</u>	
				9. AGE (in years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
						Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>			
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>ROBERT LANKFORD</u>				14. MOTHER'S MAIDEN NAME <u>FLORENCE CORBIN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>215-26-4713</u>			
				17. INFORMANT <u>LESSIE JESTER, SNOW HILL, MARYLAND</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>longest heart failure.</u> <u>411x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis + mitral valve disease</u> DUE TO (c) <u>Rheumatic fever</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9/6/1957</u> to <u>9/17/1957</u> , that I last saw the deceased alive on <u>9/17/1957</u> , and that death occurred at <u>4:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>SALISBURY, MARYLAND</u>			
PHYSICIAN'S NAME (Type) <u>O. J. BURTON</u>				DATE SIGNED <u>SEP 23 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HUTTS CHAPEL</u>		22d. LOCATION (City, town, or county) (State) <u>RURAL SNOW HILL MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry L. Watson</u>				24a. REC'D BY REGISTRAR <u>[Signature]</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



23

1957

BUREAU V. 8

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shall be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09990  
9939 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penn</b> b. COUNTY <b>Philadelphia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>Philadelphia</b> 75x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. Pen. Gen. Hospital</b>		d. STREET ADDRESS <b>2111 S. 66th St</b>	
3. NAME OF DECEASED (Type or print) <b>JOSEPH S. LESCO</b>		4. DATE OF DEATH Month <b>9</b> Day <b>11</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 22, 1911</b>
9. AGE (In years last birthday) <b>46</b> yrs.		10. IF UNDER 1 YEAR Months <b>46</b> Days <b>11</b> Hours <b>1957</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>	
11. BIRTHPLACE (State or foreign country) <b>Mahanoy, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>George Leso</b>		14. MOTHER'S MAIDEN NAME <b>Anna Walko</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unk</b>		16. SOCIAL SECURITY NO. <b>180-07-0143</b>	
17. INFORMANT <b>Mr. Michael Leso (Brother)</b>		Address <b>5753 N. 6th St. Phila. 20, Pa.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sudden</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Philip A Insley</b>		DATE SIGNED <b>9-12-57</b>	
EXAMINER'S NAME (Type) <b>Philip A Insley</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 16th, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Sepulchre Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Wydmoor Montg. Co. Penn.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		24a. REC'D BY REGISTRAR <b>SEP 16 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

SEP 16 1957

RECEIVED

9990

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>9 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS <b>Kent Narrows</b>			
3. NAME OF DECEASED (Type or print) First <b>Eugene</b> Middle <b>-</b> Last <b>Major</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>20,</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 30, 1898</b>	9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months <b>17</b> Days <b>0</b> Hours <b>2</b>	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stevodore</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Pier</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Elwood Major</b>				14. MOTHER'S MAIDEN NAME <b>Betty Lee</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Deer's Head State Hospital Records, Salisbury, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic pulmonary fibrosis, etiology undetermined</b> <b>525X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>--</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Cardiovascular Disease with Cor Pulmonale</b> INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 11, 1957</b> , to <b>Sept. 20, 1957</b> , that I last saw the deceased alive on <b>Sept. 20, 1957</b> , and that death occurred at <b>7:10 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>9/20/57</b>							
ACTUAL SIGNATURE <b>Dr. J. Juerman</b> M.D.				PHYSICIAN'S NAME (Type) <b>J. Juerman, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/25/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Anne Arundle Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Holland Funeral Home-1631 Druid Hill Ave</b> ADDRESS <b>SEP 26 1957</b>				24b. REGISTRAR'S SIGNATURE <b>Mary Holloway</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

SEP 26 1957

RECEIVED



9991

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>STOCKTON 23X0.2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>MARTIN</u> Last <u>MARTIN</u>		4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COL.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 17 1916</u>
9. AGE (In years last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FACTORY</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CLEMOND MARTIN</u>		14. MOTHER'S MARDEN NAME <u>MATTIE BLAKE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-073789</u>	
17. INFORMANT <u>Mrs. Elizabeth Tull</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malignant Hypertension</u> DUE TO (c) <u>Chronic Nephritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>unk</u> <u>unk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19__		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 7, 1957</u> to <u>Sept. 15, 1957</u> , that I last saw the deceased alive on <u>Sept. 14, 1957</u> , and that death occurred at <u>4:48 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert Sembly</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>9/15/57</u>	
PHYSICIAN'S NAME (Type) <u>G. Herbert Sembly</u>		<u>Salisbury Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/21/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Stockton cemi.</u>		22d. LOCATION (City, town, or county) (State) <u>Stockton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton</u>		ADDRESS <u>new church</u>	
24a. REC'D BY REGISTRAR <u>223-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary M. Holm</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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SEP 25 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9992 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09994

Reg. Dist. No.

321

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b> <b>2342.2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General</b>		d. STREET ADDRESS <b>Pocomoke</b>	
3. NAME OF DECEASED (Type or print) First <b>Genevia</b> Middle <b>Milbourne</b> Last		4. DATE OF DEATH Month <b>Sept.</b> Day <b>29</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 7, 1909</b>
9. AGE (In years last birthday) <b>48</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Mpnths Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard George</b>		14. MOTHER'S MAIDEN NAME <b>Nettie Savage</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Warner Milbourne - Pocomoke, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured skull</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>823x</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>40 min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in a car that ran off road.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>10P</b> a. m. <b>2-29-57</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) <b># 113</b> (County) <b>Wicomico</b> (State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 5, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>George Town Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pocomoke, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar W. Horton</b>		ADDRESS <b>- new Church, Va.</b>	
24a. REC'D BY REGISTRAR <b>DATE 7 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary H. Williams</b>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 8

OCT 7 1957

RECEIVED

9993

## CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
c. LENGTH OF STAY IN 1b <u>22 days</u>				d. STREET ADDRESS <u>406 W. Isabella St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary KATIE</u> First Middle Last				4. DATE OF DEATH <u>September 26 1957</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-7-1895</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Furr</u>				14. MOTHER'S MAIDEN NAME <u>Heneritta Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-30-8567-A</u>		17. INFORMANT <u>Mrs. Cora Jones</u>		Address <u>406 W. Isabella St., Salisbury, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>3 weeks</u> Interval between onset and death <u>years</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept 17</u> , 19 <u>57</u> , to <u>Sept 26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 25</u> , 19 <u>57</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Rufus S. Gardner, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>321 S. Div. St., Salisbury, Md.</u>			
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR.</u>				DATE SIGNED <u>9/27/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Acres Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. P. Stewart Funeral Home, Salisbury, Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 30 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mary K. Holloway</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

## CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		35		M		W		10/6/68		MEMPHIS, TENN.	
BIRTH DATE		BIRTH PLACE		MARRIAGE DATE		MARRIAGE PLACE		EDUCATION		OCCUPATION	
10/24/33		MEMPHIS, TENN.		10/24/60		MEMPHIS, TENN.		HIGH SCHOOL		COUNSELOR	
PREVIOUS MARRIAGES		CAUSE OF DEATH		MANNER OF DEATH		IMMEDIATE CAUSE		UNDERLYING CAUSE		MORBID CAUSE	
None		Suicide		Suicide		Suicide		Suicide		Suicide	
DATE OF BURIAL		PLACE OF BURIAL		DATE OF EXAMINATION		PLACE OF EXAMINATION		DATE OF SIGNATURE		PLACE OF SIGNATURE	
10/10/68		MEMPHIS, TENN.		10/6/68		MEMPHIS, TENN.		10/6/68		MEMPHIS, TENN.	

BUREAU V. 2

SEP 30 1967

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>5 Hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>			d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Maxwell</u> Middle <u>James</u> Last <u>Moore</u>			4. DATE OF DEATH Month <u>9</u> Day <u>7</u> Year <u>19 57</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12/25/1900</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>12</u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>File Driving CO.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>George D. Moore</u>			14. MOTHER'S MAIDEN NAME <u>Mary W. Webster</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>WW 2</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. Raymond Moore, Delmar, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Earl L. Royer</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9-9-57</u>		
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bivalve Cen.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. D. Wessink</u>		ADDRESS <u>Bivalve, Maryland</u>		24c. REC'D BY REGISTRAR <u>SEP 11 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary D. Holloway</u>					

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH



BUREAU V. 5

SEP 11 1957

RECEIVED

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wiconico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wiconico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>40 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>406 W. Isabella St.</b>		d. STREET ADDRESS <b>406 W. Isabella St.</b>	
3. NAME OF DECEASED (Type or print) <b>Zorah H. Moore</b>		4. DATE OF DEATH <b>Sept. 1 1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>AA</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-19-1884</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City of Salisbury Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lemuel Moore</b>		14. MOTHER'S MAIDEN NAME <b>Eliza ? Moore</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-10-8490</b>	
17. INFORMANT <b>Mrs. Katie Moore, 406 W. Isabella St.,</b>		Address <b>Salisbury, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shot wound left ventricle</b> <b>982x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Struck by knife in left chest</b>	
20c. TIME OF INJURY Month, Day, Year Hour p.m. <b>4:00 1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>406 W Isabella</b>		20f. (City or town) <b>Salisbury, Md.</b> (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Philip A. Insley</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Philip A. Insley</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>9-3-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-4-1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Green Acre Memorial Park</b>		22d. LOCATION (City, town, or county) <b>Salisbury, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Stewart Funeral Home, Salisbury, Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 6 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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21-10-2000 Mr. Eusebio, 408 W. Imperial St.,

BUREAU V. S.

SEP 6 1957

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U. S. District Court, Eastern District of New York



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Permit Item 2, Film G222, 10/31/57 fcy

## CERTIFICATE OF DEATH

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337

Reg. Dist. No.

<p>1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY</p>			
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u></p>				<p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belle Glade</u></p>			
<p>c. LENGTH OF STAY IN 1b <u>21 days</u></p>				<p>d. STREET ADDRESS <u>48X-3</u></p>			
<p>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u></p>				<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/></p>			
<p>3. NAME OF DECEASED (Type or print) First <u>C.B.</u> Middle Last <u>PERRIN</u></p>				<p>4. DATE OF DEATH <u>September 13 - 1957</u></p>			
<p>5. SEX <u>male</u></p>		<p>6. COLOR OR RACE <u>colored</u></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>46</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) <u>Georgia</u></p>	
<p>13. FATHER'S NAME <u>7</u></p>				<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u></p>			
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)</p>				<p>16. SOCIAL SECURITY NO.</p>			
<p>17. INFORMANT <u>Mrs. Oliver Redding</u> Address <u>Purcell Lane Md.</u></p>				<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Cardiac Vascular Renal</u> DUE TO <u>4 weeks</u> (c)</p>			
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>023X</u> <u>Latent Rheum.</u></p>				<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>			
<p>20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u></p>				<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>	
<p>20f. (City or town) (County) (State)</p>				<p>21. I certify that I attended the deceased from <u>Aug. 23, 1957</u> to <u>Sept. 13, 1957</u>, that I last saw the deceased alive on <u>Sept. 13, 1957</u>, and that death occurred at <u>4 P.M.</u>, from the causes and on the date stated above.</p>			
<p>ACTUAL SIGNATURE <u>G. Herbert Sembly</u> M.D. <u>400 E. Church St.</u></p>				<p>DATE SIGNED <u>9/13/57</u></p>			
<p>PHYSICIAN'S NAME (Type) <u>G. Herbert Sembly</u></p>				<p>ADDRESS (Street, city or town, state) <u>Salisbury Md.</u></p>			
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>22b. DATE THEREOF <u>Sept 16 1957</u></p>		<p>22c. NAME OF CEMETERY OR CREMATORY <u>Pokes Cemetery</u></p>		<p>22d. LOCATION (City, town, or county) (State) <u>Mt. Vernon Md.</u></p>	
<p>23. FUNERAL DIRECTOR'S SIGNATURE <u>James Harmon</u> ADDRESS <u>Purcell Lane Md.</u></p>				<p>24a. REC'D BY REGISTRAR <u>SEP 19 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u></p>			

CERTIFICATE OF DEATH

Reg. No. 100

MARYLAND

21 days

BUREAU V. 1

SEP 19 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9997 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09999331

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>At Home R.D.# 5</b>				d. STREET ADDRESS <b>R.D.# 5</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>OLEY</b> Middle <b>WASHINGTON</b> Last <b>PILCHARD</b>				4. DATE OF DEATH Month <b>September</b> Day <b>21st</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 2, 1892</b>		9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Meat Cutter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Butcher</b>		11. BIRTHPLACE (State or foreign country) <b>Stockton, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Stephen J. Pilchard</b>				14. MOTHER'S MAIDEN NAME <b>Frances Scott</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. James S. Pilchard (Son) R.D.# 5 Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>420.1</b> DUE TO (c) <b>420.1</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b></b> o. m. <b></b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Earl L. Royer</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 23, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24a. REC'D BY REGISTRAR <b>SEP 24 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary Holloway</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

SEP 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9998

## CERTIFICATE OF DEATH

10000

Reg. Dist. No. 332

Items 6 & 7, Film G220, 9/26/57

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>				c. LENGTH OF STAY IN 1b <b>8 HOURS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>82 PENINSULA GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>GREEN BACKVILLE 13X-3</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM PRUITT</b>				4. DATE OF DEATH Month Day Year <b>SEPTEMBER 20 1957</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 8 1907</b>		9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee of Budape Chicken plant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Y.A.</b>		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>WILLIAM PRUITT</b>				14. MOTHER'S MAIDEN NAME <b>Bertie Tull</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Mrs. Matilda Pettett</b> Address <b>Wilmington, Del.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Embolus</b> <b>416X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rheumatic Heart Disease</b> DUE TO (c) <b>Unknown</b>						INTERVAL BETWEEN ONSET AND DEATH <b>7 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Sept. 20, 1957</b> , to <b>Sept. 20, 1957</b> , that I last saw the deceased alive on <b>Sept. 20, 1957</b> , and that death occurred at <b>7:30 PM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <b>Blair J. Gilmore M.D.</b>				<b>Salisbury Md. Sept. 20, 1957</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Sept 22 1957</b>		<b>Greenback</b>		<b>Greenbackville VA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mrs. D. A. Shells</b> ADDRESS <b>7 New Church Rd.</b>				24a. REC'D BY REGISTRAR <b>DATE 9-23-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary W. Holloway</b>	



CERTIFICATE OF DEATH

See also p. 10

10-10-57

BUREAU V. 3

SEP 04 1957

RECEIVED

9999

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SNOW HILL 23x0.2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELBERT</u> First <u>Redden</u> Middle Last		4. DATE OF DEATH <u>September 8</u> 19 <u>57</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 4 - 1895</u> 9. AGE (In years last birthday) <u>61/9/4</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Saw mill</u>	
11. BIRTHPLACE (State or foreign country) <u>Snow Hill, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Armstrong</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>320-12-1776</u> 17. INFORMANT <u>Frank Redden</u> Address <u>Snow Hill, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute embolus</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-17-57</u> to <u>9-8-57</u> , that I last saw the deceased alive on <u>9-8-57</u> , 19 <u>57</u> , and that death occurred at <u>11:55A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>226 N. Alvin St.</u> DATE SIGNED <u>Carrie I. Hearn</u>			
ACTUAL SIGNATURE <u>Carrie I. Hearn</u> M.D.		PHYSICIAN'S NAME (Type) <u>CARRIE I. HEARN</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Sept 12/57</u>	<u>St. Wesley</u>	<u>Snow Hill, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>May E. Dennis</u> ADDRESS <u>Snow Hill, Md</u>		24. REC'D BY REGISTRAR <u>SEP 11 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mary H. Hollaway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

September 1 1957

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SEP 11 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
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100000 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 100000 CERTIFICATE OF DEATH

Reg. Dist. No.

10002331

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>8 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 MARDELLA</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FANNIE LEE REDDISH</u>				4. DATE OF DEATH Month Day Year <u>SEPTEMBER 22 1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 25, 1884</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>27</u> Hours <u></u> Min. <u></u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work at Home</u>	
10a.		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Wicomico Co. Near Mardela, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Samuel J. Phillips</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Cox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. George E. Reddish (Husband)</u> Address <u>Main St. Box 99 Mardela, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>9-22</u> , 19 <u>57</u> , and that death occurred at <u>2:40</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Wilber J. Ellis, Jr.</u> M.D. <u>Medical Center - Salisbury, Md</u> <u>Sept. 22/57</u> PHYSICIAN'S NAME (Type) <u>Dr. Wilber J. Ellis, Jr.</u> <u>9/22/57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 24, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mardela Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mardela, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</u>				24. REC'D BY REGISTRAR <u>SEP 24 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

MEDICAL CERTIFICATION

7961 26 255

RECEIVED



10001

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ruby</u> Middle <u>TOADVINE</u> Last <u>Roberts</u>		4. DATE OF DEATH Month <u>9</u> Day <u>27</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 9, 1876</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY TOADVINE</u>		14. MOTHER'S MAIDEN NAME <u>MARY POLLITT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>HENRY B. ROBERTS</u> Address <u>SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Coronary Occlusion</u> <u>420.1</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Dis.</u> (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/19</u> , 19 <u>57</u> , to <u>9/27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/24</u> , 19 <u>57</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>S. Division St., Salisbury, Md.</u> DATE/SIGNED <u>9/27/57</u>			
ACTUAL SIGNATURE <u>Rufus Gardner</u> M.D.			
PHYSICIAN'S NAME (Type) <u>RUFUS GARDNER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/29/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hill &amp; Johnson Co.</u> ADDRESS <u>Salisbury, Md.</u>		24a. REC'D BY REGISTRAR <u>Franklin B. Hill Jr.</u> DATE <u>9-20-57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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## CERTIFICATE OF DEATH

Reg. Dist. No.

10004

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Greenwood 46X-3</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Alexander</u> First <u>Sadowski</u> Middle Last			4. DATE OF DEATH <u>September 28</u> Month <u>1957</u> Day Year				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 9 1896</u>	9. AGE (in years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hosiery manufacture</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>				
11. BIRTHPLACE (State or foreign country) <u>Poland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Joseph Sadowski</u>			14. MOTHER'S MAIDEN NAME <u>Jula Landzberger</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>work war I</u>		16. SOCIAL SECURITY NO. <u>22209-3897</u>	17. INFORMANT <u>Jennie Sadowski</u> Address <u>Greenwood Delaware</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X</u> DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Atherosclerosis</u> DUE TO (c) <u>Unknown</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u> <u>Diabetes Mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Salisbury</u>	(County)	(State)		
21. I certify that I attended the deceased from <u>Sept. 26, 1957</u> , to <u>Sept. 28, 1957</u> , that I last saw the deceased alive on <u>Sept. 28, 1957</u> , and that death occurred at <u>5:05 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Md</u>		DATE SIGNED <u>Sept. 28, 1957</u>			
PHYSICIAN'S NAME (Type) <u>Dr. David J. Gilmore</u>		Medical Center Salisbury, Md. <u>Sept. 28, 1957</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 1-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>our lly of Loudres</u>	22d. LOCATION (City, town, or county) <u>Blades</u>	(State) <u>Delaware</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>FLEISCHAUER FUNERAL HOME - GREENWOOD, DELAWARE</u>		24a. REC'D BY REGISTRAR <u>Oct 5 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, and cause of death. The form is mostly blank with some faint, illegible markings.

1991

BUREAU V. 1

OCT - 3 1957

RECEIVED

10003

## CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH o. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u> 23 x 2.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>MARKET STREET</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>B.</u> Last <u>SARTORIUS</u>		4. DATE OF DEATH Month <u>September</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 17, 1880</u> 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLOTHIER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM SARTORIUS</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN ELLIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>822-09-6909</u>	
17. INFORMANT <u>DR. N.E. SARTORIUS SR.</u>		Address <u>POCOMOKE, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO (b) <u>Cerebral Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 30</u> , 19 <u>57</u> , to <u>Sept. 1</u> , 19 <u>57</u> that I last saw the deceased alive on <u>Sept. 1</u> , 19 <u>57</u> , and that death occurred at <u>5:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Md.</u> DATE SIGNED <u>Sept. 1, 1957</u>	
PHYSICIAN'S NAME (Type) <u>DAVID J. GILMORE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9-2-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BETHANY METHODIST</u>	22d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u> ADDRESS <u>POCOMOKE, MD.</u>		24a. REC'D BY REGISTRAR <u>SEP 4 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 19  
 CERTIFICATE OF DEATH

Decedent's Name: *William*  
 Sex: *Male*  
 Race: *White*  
 Date of Birth: *1912*  
 Place of Birth: *Germany*  
 Usual Residence: *1000*  
 Cause of Death: *Heart*

*General Thomas*  
*General Thomas*

BUREAU V. S.  
 SEP 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1  
BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10004

CERTIFICATE OF DEATH

10008 ✓

Reg. Dist. No. 201

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>3 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>nr Chestertown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Roy</b> Middle <b>Edward</b> Last <b>Scott</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>16</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/18/1922</b>	
9. AGE (In years last birthday) yrs. <b>35</b>		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dairyman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Dairy</b>		14. MOTHER'S MAIDEN NAME <b>Pluma Masden</b>	
13. FATHER'S NAME <b>Leroy Scott</b>				17. INFORMANT <b>Hospital Records</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>YES WW 2</b>				16. SOCIAL SECURITY NO. <b>319-14-302</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recurrent cerebral hemorrhage</b> <b>330x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Intracranial cerebral vascular aneurysm</b> DUE TO (c) <b>?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 18</b> , 19 <b>57</b> , to <b>Sept. 16</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Sept. 16</b> , 19 <b>57</b> , and that death occurred at <b>3:55 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>9/16/57</b> ACTUAL SIGNATURE <b>V. Juerman</b> M.D. <b>Salisbury, Maryland</b> PHYSICIAN'S NAME (Type) <b>V. Juerman, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9-20-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>DENTON CEMTY</b>		22d. LOCATION (City, town, or county) (State) <b>DENTON MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Victor N. Kennedy</b>				ADDRESS <b>STILL POND, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>9/16/57</b>	
						24b. REGISTRAR'S SIGNATURE <b>May H. Holloway</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

YES ☒ W M J 819-14-382

BUREAU V. S.

SEP 18 1957

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10018

## CERTIFICATE OF DEATH

10007332

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bivalve</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>x2 Bivalve</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Estelle</b> Middle <b>Somers</b> Last				4. DATE OF DEATH Month <b>September</b> Day <b>23</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/28/1876</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months <b>2</b> Days <b>3</b> Hours <b></b> Min.	IF UNDER 24 HRS. Hours <b></b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>George C. Horseman</b>				14. MOTHER'S MAIDEN NAME <b>Julia Ann Wainwright</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>-----</b>			
17. INFORMANT <b>Mrs. Sheldon Hopkins, Mount Vernon, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic Heart Disease</b> DUE TO (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>23 May, 1948</b> to <b>28 Sept., 1957</b> that I last saw the deceased alive on <b>23 Sept., 1957</b> , and that death occurred at <b>2:15 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Nanticoke, Md.</b> DATE SIGNED <b>9/26/57</b>							
ACTUAL SIGNATURE <b>Richard H. Saunders M.D.</b>				PHYSICIAN'S NAME (Type) <b>Richard H. Saunders</b> <b>Nanticoke, Maryland</b> <b>9/26/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/26/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Turners Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Nanticoke, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE - <b>C. H. Mesner</b> <b>Bivalve, Maryland</b>				24a. REC'D BY REGISTRAR <b>OCT 8 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. A.

OCT 8 1957

RECEIVED



## CERTIFICATE OF DEATH

10008

Reg. Dist. No. 332

10005

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>5½ months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS <b>23x0.2</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Amanda</b> Middle <b>Spence</b> Last <b>Spence</b>				4. DATE OF DEATH Month <b>September</b> Day <b>28</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/3/1880</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Robert Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Sallie Johnson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Inoperable epidermoid cancer of uterus with metastasis</b> <b>174X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <input type="checkbox"/> DUE TO (c) <input type="checkbox"/>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>April 8</b> , 19 <b>57</b> , to <b>Sept. 28</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Sept. 27</b> , 19 <b>57</b> , and that death occurred at <b>2:30A</b> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b>				DATE SIGNED <b>9/28/57</b>			
ACTUAL SIGNATURE <b>Dr. V. Juerman</b>				M.D. <b>Salisbury, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>V. Juerman, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-1-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Chapel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Newark, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Stewart Funeral Home, Salisbury, Md</b>				ADDRESS <b>Salisbury, Md</b>		24a. REC'D BY REGISTRAR DATE <b>10-2-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary Holloway</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10006

## CERTIFICATE OF DEATH

Reg. Dist. No.

1000332

1. PLACE OF DEATH a. COUNTY <b>WICOMICO</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>				c. LENGTH OF STAY IN 1b <b>35 min.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PENINSULA General Hospital</b>				d. STREET ADDRESS <b>Beckford Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Eugene</b> Middle <b>W.</b> Last <b>TAYLOR</b>				e. DATE OF DEATH Month <b>September</b> Day <b>1</b> Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 10, 1891</b>	
9. AGE (in years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Eugene M. Taylor</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Dolbey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-34-5209</b>			
17. INFORMANT <b>John Symmons Princess Anne</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Atherosclerosis</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>4 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Sept. 1, 1957</b> to <b>Sept. 1, 1957</b> that I last saw the deceased alive on <b>Sept. 1, 1957</b> , and that death occurred at <b>7:05 AM</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>David J. Gilmore</b>				DATE SIGNED <b>Salisbury Md. Sept. 1, 1957</b>			
PHYSICIAN'S NAME (Type) <b>1</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/3/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Manokin Presbyterian</b>		22d. LOCATION (City, town, or county) (State) <b>Princess Anne Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Kemmer Princess Anne Md</b>				24a. REC'D BY REGISTRAR <b>SEP 9 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Henry J. Holloway</b>	

WILSON		MARRIAGE	
SALLY ANN		35 min	
Pringle General Hospital			
MALE		WHITE	
TAYLOR		September 1, 1957	
Backford Ave		Princess Anne	
SOMERSET		MARRIAGE	

BUREAU V. 3  
SEP 9 1957

RECEIVED

10007

Item 11 Film G220 9-23-57 et

## CERTIFICATE OF DEATH

10010

Reg. Dist. No.

337

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NO R.D.# Salisbury (Rural)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PENINSULA GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>Meadow Bridge Rd</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>HUBLEN</b> Middle <b>BERMA</b> Last <b>TAYLOR</b>				4. DATE OF DEATH Month <b>September</b> Day <b>16</b> Year <b>1957</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 8th, 1901</b>	
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee (John H. Dulany &amp; Sons) Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Connecticut</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Woolford G. Nadeau</b>				14. MOTHER'S MAIDEN NAME <b>Alice Sanderson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Evelyn M. Schneider (Sister)</b> Address <b>28 Willet Place Roosevelt, New York - Long Island - N.Y.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>416X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rheumatic Heart Disease</b> DUE TO (c) <b>unknown</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>9/15/57</b> , to <b>9-16-1957</b> , that I last saw the deceased alive on <b>19</b> , and that death occurred at <b>11 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William R. Ellis, Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>Medical Center-Salisbury, Md</b> DATE SIGNED <b>Sept. 16/57</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Wilbur R. Ellis, Jr.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 19, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenfield Cemetery - Hemstead - Long Island - New York</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b> ADDRESS				24a. REC'D BY REGISTRAR <b>SEP 18 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary Holloway</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		10/15/1957		NEW YORK, N.Y.	
MARRIAGE		DATE		PLACE		NAME OF SPouse		DATE OF BIRTH		PLACE OF BIRTH	
MARRIED		1935		NEW YORK		JANE HARRIS		1915		NEW YORK	
EDUCATION		SCHOOL		DEGREE		NAME OF SCHOOL		DATE OF GRADUATION		PLACE OF GRADUATION	
HIGH SCHOOL		NEW YORK		B.S.		COLUMBIA UNIVERSITY		1940		NEW YORK	
OCCUPATION		BUSINESS		NAME OF EMPLOYER		DATE OF EMPLOYMENT		PLACE OF EMPLOYMENT		DATE OF DEATH	
MANAGER		ABC COMPANY		1945		NEW YORK		NEW YORK		10/15/1957	
CAUSE OF DEATH		DISEASE		SYMPTOMS		DATE OF ONSET		PLACE OF ONSET		DATE OF DEATH	
HEART DISEASE		ANGINA PECTORIS		Chest pain		10/10/1957		NEW YORK		10/15/1957	
MANNER OF DEATH		NATURAL		ACCIDENT		SUICIDE		HOMICIDE		DATE OF DEATH	
NATURAL		NEW YORK		NEW YORK		NEW YORK		NEW YORK		10/15/1957	
SIGNATURE OF PHYSICIAN		DATE		PLACE		NAME OF PHYSICIAN		DATE OF BIRTH		PLACE OF BIRTH	
J. H. HARRIS		10/15/1957		NEW YORK		J. H. HARRIS		1915		NEW YORK	
SIGNATURE OF REGISTRAR		DATE		PLACE		NAME OF REGISTRAR		DATE OF BIRTH		PLACE OF BIRTH	
J. H. HARRIS		10/15/1957		NEW YORK		J. H. HARRIS		1915		NEW YORK	

BUREAU V. S.

SEP 18 1957

RECEIVED

1. MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10008

CERTIFICATE OF DEATH

10011 337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SNOW HILL 23x22</u>	
c. LENGTH OF STAY IN 1b <u>4 m</u>		d. STREET ADDRESS <u>307 WILLOW STREET</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Girl</u>		4. DATE OF DEATH <u>SEPTEMBER 12 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPTEMBER 12, 1957</u>
9. AGE (In years last birthday) yrs. <u>4</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Salisbury, Md</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Francis M. Truitt</u>		14. MOTHER'S MAIDEN NAME <u>Alice Linley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Francis M. Truitt</u>		Address <u>307 Willow St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ante partum foetal distress</u> DUE TO <u>769.4</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Secondary to obesity and</u> DUE TO <u>hypertension (maternal)</u> (c) <u>1 minute</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 12 1957</u> to <u>Sept 12 1957</u> that I last saw the deceased alive on <u>Sept 12 1957</u> , and that death occurred at <u>7:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Cowen</u> M.D.		ADDRESS (Street, city or town, state) <u>Snow Hill Md</u>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>May E. Dennis</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Sept 14/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chesapeake Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Snow Hill Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>May E. Dennis</u>		24. REC'D BY REGISTRAR <u>SEP 16 1957</u>	
ADDRESS <u>Snow Hill, Md</u>		25. REGISTRAR'S SIGNATURE <u>Mary T. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4. may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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U.S. DEPARTMENT OF HEALTH - BALTIMORE, MD

RECEIVED  
SEP 16 1957

10019

CERTIFICATE OF DEATH

10012

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela</b>		c. LENGTH OF STAY IN 1b <b>X2</b> <b>Mardela</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Main St</b>		d. STREET ADDRESS <b>Main St (At Home)</b>	
3. NAME OF DECEASED (Type or print) First <b>JOSIAH (JOSEPH)</b> Middle <b>COLLINS</b> Last <b>TRUITT</b>		4. DATE OF DEATH Month <b>SEPT.</b> Day <b>26</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 12, 1872</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (State or foreign country) <b>Dorchester Co. Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Philip Thomas Truitt</b>	
14. MOTHER'S MAIDEN NAME <b>Ann Vincent</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Margaret C. Truitt (Wife)</b> Address <b>Main St. Mardela, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolus</b> <b>177X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of prostate</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>2 yrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Medical Center - Salisbury, Md.</b> DATE SIGNED <b>Sept. 28/57</b>			
ACTUAL SIGNATURE <b>William H. Fisher</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dr. William Fisher</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 29, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mardela Cemetery</b>
22d. LOCATION (City, town, or county) <b>Mardela, Maryland</b>		22e. (State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		24a. REC'D BY REGISTRAR <b>SEP 30 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 30 1957

RECEIVED



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## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10009

## CERTIFICATE OF DEATH

10013

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>Since 6/25/57</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Federalsburg</u>		<u>05x0-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>William</u> (Middle) <u>Bryan</u> (Last) <u>Tull</u>				(Month) <u>Sept.</u> (Day) <u>23</u> (Year) <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept. 25, 1900</u>	9. AGE last birthday <u>56</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Button Cutter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Button Mfg.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Eben Tull</u>				14. MOTHER'S MAIDEN NAME <u>Alverda Hopkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Patient when admitted to hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
465X IMMEDIATE CAUSE (A) <u>Pulmonary Infarct</u>						6 days	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C) <u>Pulmonary fibrosis</u>						unk.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cardiac decompensation</u>						6 days	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>6/25</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/25</u> , 19 <u>57</u> , to <u>9/23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/22</u> , 19 <u>57</u> , and that death occurred at <u>8:32A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Edward P. Ritchings</u>		M.D.		ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>9/23/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept. 26, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		LOCATION (City, town, or county) (State) <u>Federalsburg, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>9-27-57</u>		REGISTRAR'S SIGNATURE <u>Mary W. Hollman</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J.J. Frampton and Son, Federalsburg, Md.</u>			

# CERTIFICATE OF DEATH

Form No. 10

1. Usual Residence (Home or Hospital)

2. Place of Death

3. Date of Death

4. Name of Deceased

5. Sex

6. Age

7. Race

8. Occupation

9. Cause of Death

10. Date of Birth

11. Signature of Physician

12. Signature of Registrar

13. Date of Registration

14. Signature of Coroner

15. Signature of Medical Examiner

16. Date of Examination

17. Signature of Jury

18. Signature of Jury Foreman

19. Date of Verdict

20. Signature of Jury Foreman

21. Signature of Jury Foreman

22. Date of Verdict

23. Signature of Jury Foreman

24. Signature of Jury Foreman

25. Date of Verdict

26. Signature of Jury Foreman

27. Signature of Jury Foreman

28. Date of Verdict

29. Signature of Jury Foreman

30. Signature of Jury Foreman

31. Date of Verdict

32. Signature of Jury Foreman

33. Signature of Jury Foreman

34. Date of Verdict

35. Signature of Jury Foreman

36. Signature of Jury Foreman

37. Date of Verdict

38. Signature of Jury Foreman

39. Signature of Jury Foreman

40. Date of Verdict

41. Signature of Jury Foreman

42. Signature of Jury Foreman

43. Date of Verdict

44. Signature of Jury Foreman

45. Signature of Jury Foreman

46. Date of Verdict

47. Signature of Jury Foreman

48. Signature of Jury Foreman

49. Date of Verdict

50. Signature of Jury Foreman

49. Signature of Jury Foreman

50. Date of Verdict

51. Signature of Jury Foreman

50. Signature of Jury Foreman

51. Date of Verdict

52. Signature of Jury Foreman

51. Signature of Jury Foreman

52. Date of Verdict

53. Signature of Jury Foreman

52. Signature of Jury Foreman

53. Date of Verdict

54. Signature of Jury Foreman

53. Signature of Jury Foreman

54. Date of Verdict

55. Signature of Jury Foreman

54. Signature of Jury Foreman

55. Date of Verdict

56. Signature of Jury Foreman

55. Signature of Jury Foreman

56. Date of Verdict

57. Signature of Jury Foreman

56. Signature of Jury Foreman

57. Date of Verdict

58. Signature of Jury Foreman

57. Signature of Jury Foreman

58. Date of Verdict

59. Signature of Jury Foreman

58. Signature of Jury Foreman

59. Date of Verdict

60. Signature of Jury Foreman

BUREAU V. 3

SEP 30 1957

RECEIVED

NOTIFICATION

## CERTIFICATE OF DEATH

10014  
Reg. Dist. No. 331

10010

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>5 Yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>306 Charles St.</b>				d. STREET ADDRESS <b>306 Charles St.</b>			
3. NAME OF DECEASED (Type or print) <b>MINNIE TYNDALL</b>				4. DATE OF DEATH <b>9 2 19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 9, 1872</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John Bennett</b>				14. MOTHER'S MAIDEN NAME <b>Biddie Unknow</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>George T. Simpson, Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan 19 57</b> , to <b>Sept 2 19 57</b> , that I last saw the deceased alive on <b>Sept 1 19 57</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>9/4/57</b>							
ACTUAL SIGNATURE <b>William D. Gray</b>				M.D. <b>Salisbury, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Dr. William D. Gray, 334 Camden Ave., Salisbury, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/4/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Maryland</b>				ADDRESS <b>Norman F. Baker</b>		24a. REC'D BY REGISTRAR <b>9-4-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary W. Holloway</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

10020

232

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Salisbury</b>				c. LENGTH OF STAY IN 1b <b>x2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box #98 Oak Lee Dr. (Shad Point)</b>				d. STREET ADDRESS <b>Box #98 Oak Lee Dr. (Shad Point)</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>First</b> <b>EMULAH</b> <b>Middle</b> <b>MYRTLE</b> <b>Last</b> <b>WARWICK</b>		4. DATE OF DEATH <b>Month</b> <b>SEPT.</b> <b>Day</b> <b>7 th</b> <b>Year</b> <b>19 57</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 31, 1882</b>		9. AGE (In years lost birthday) <b>75 yrs.</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>6</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Somerset Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>James Dodson</b>				14. MOTHER'S MAIDEN NAME <b>Ida Townsend</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. James R. Warwick (Son) 215 W. Vine St. Salisbury</b> <b>Mr. James U. Warwick (Husband) Box #98 Shad Point</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>433.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Auricular Fibrillation</b> DUE TO (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>2 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 1957</b> , 19____, to <b>Sept. 7</b> , 19____, that I last saw the deceased alive on <b>9-7-57</b> , 19____, and that death occurred at <b>4:15 P.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Lee L Lawry</b>		M.D. <b>Fruitland, Md.</b>		ADDRESS (Street, city or town, state)		DATE SIGNED <b>Sept. 9 /57</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Lee Lawry</b>		<b>Fruitland, Maryland</b>		<b>Sept. 9 /57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept. 10, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24a. REC'D BY REGISTRAR <b>SEP 10 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary H Holloway</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

SEP 10 1957

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

10011

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>19x2.2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Wenona</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Webster</u> Last <u>Webster</u>				4. DATE OF DEATH Month <u>September</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2 1888</u>		9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>		11. BIRTHPLACE (State or foreign country) <u>US</u>	
13. FATHER'S NAME <u>Jesse H Webster</u>				14. MOTHER'S MAIDEN NAME <u>Louise Windsor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>820-320904</u>		17. INFORMANT Address <u>Walton Webster Wenona Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Degenerative Heart Disease</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Embolism</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>11</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9-22-1957</u> , to <u>9-22-1957</u> , that I last saw the deceased alive on <u>10-14-57</u> , and that death occurred at <u>10:40</u> M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>William R. Ellis, Jr.</u> M.D. <u>Salisbury, Md.</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept 22 1957</u>		<u>Wenona Cemetery</u>		<u>Wenona Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	
<u>Leroy L. Webster</u> <u>Pea Island Rd</u>				<u>9/21/57</u>		<u>Lola J. Hollaway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

**RECEIVED**  
 SEP 27 1957  
 BUREAU V. 1

NAME OF DECEASED _____	
SEX _____	
AGE _____	
DATE OF BIRTH _____	
PLACE OF BIRTH _____	
OCCUPATION _____	
CAUSE OF DEATH _____	
PLACE OF DEATH _____	
DATE OF DEATH _____	
TIME OF DEATH _____	
SIGNATURE OF PHYSICIAN _____	
SIGNATURE OF REGISTRAR _____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10012

## CERTIFICATE OF DEATH

10017332

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>Sussex</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>2½ yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Hill Private Sanitarium</b>		d. STREET ADDRESS <b>Delaware Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Carl</b> Middle <b>Cleveland</b> Last <b>West</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>5,</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 13, 1884</b>
9. AGE (In years last birthday) <b>72</b>		10. IF UNDER 1 YEAR Months <b>72</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Matthew Thomas West</b>		14. MOTHER'S MAIDEN NAME <b>Mary Virginia Ellis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>John P. West, Delmar, Del.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Atherosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Sept. 20, 1955</b> to <b>Sept. 5, 1957</b> , that I last saw the deceased alive on <b>Sept 5, 1957</b> , and that death occurred at <b>12:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>David J. Gilmore</b> M.D.		ADDRESS (Street, city or town, state) <b>Salisbury, Md.</b>	
PHYSICIAN'S NAME (Type) <b>David J. Gilmore, M.D.</b>		DATE SIGNED <b>Sept. 5, 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-8-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill</b>		22d. LOCATION (City, town, or county) <b>Laurel, Delaware</b> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. S. Gorman Co - Delmar, Del.</b>		24. REC'D BY REGISTRAR <b>SEP 11 1957</b> REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>	

RECEIVED



10013

## CERTIFICATE OF DEATH

Reg. Dist. No.

331

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>12</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES THOMAS WHAYLAND</u>				4. DATE OF DEATH Month Day Year <u>SEPTEMBER 21 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23rd, 1891</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>1 28</u>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundry Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Charles Whayland</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Priscilla Brumbley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Madeline G. Whayland (Wife) 613 Oak Hill Ave. Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchial Carcinoma</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/1</u> , 19 <u>57</u> , to <u>9/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/21</u> , 19 <u>57</u> , and that death occurred at <u>10P M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>W. B. Smith</u> M.D. <u>Med. Center Sby Md 9/21/57</u> PHYSICIAN'S NAME (Type) <u>Dr. William B. Smith</u> <u>Medical Center -Salisbury, Md</u> <u>Sept 21, 1957</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 25, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 24 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary K Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature.

BUREAU V. S.

SEP 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10021

CERTIFICATE OF DEATH

Reg. Dist. No. 100132

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willards</b>				c. LENGTH OF STAY IN 1b <b>45yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>XXX</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LEE First ANNA Middle WHITE Last</b>				4. DATE OF DEATH <b>Sept. 23 19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 4 1876</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during part of working life; then if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Walter Arvey White</b>				14. MOTHER'S MAIDEN NAME <b>Maggie Davis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Mrs. Annie Lafferty</b>		Address <b>Willards, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension - arteriosclerosis</b> DUE TO (c) <b>10-15 yrs</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3-5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>totally blind for 5 yrs (retinal hemorrhages)</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <b>1937</b> , 19____, to <b>9-23-1957</b> , that I last saw the deceased alive on <b>9-23 1957</b> , and that death occurred at <b>69</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Frank Lewis</b>				ADDRESS (Street, city or town, state) <b>Willards Maryland</b>			
DATE SIGNED <b>9-24-57</b>							
PHYSICIAN'S NAME (Type) <b>Frank R. Lewis</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/25/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Hope</b>		22d. LOCATION (City, town, or county) (State) <b>Willards, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Peter Whaley</b>				24. REG'D BY REGISTRAR <b>SEP 26 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary Holloway</b>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

337

10022

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Pittsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X / Pittsville (Rural)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.#</b>		d. STREET ADDRESS <b>R.D.#</b>	
3. NAME OF DECEASED (Type or print) First <b>STELLA</b> Middle <b>MAE</b> Last <b>WHITE</b>		4. DATE OF DEATH Month <b>SEPT.</b> Day <b>6</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 3, 1899</b>
9. AGE (In years lost birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>0</b> Days <b>3</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Parsonsburg, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Eligah Driscoll</b>		14. MOTHER'S MAIDEN NAME <b>Unk</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service. <b>No</b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mr. Herman B. White (Husband)</b>		Address <b>R.D.# Pittsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery occlusion</b> DUE TO <b>Hypertension arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>10-15 minutes</b> <b>5-8 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>	
21. I certify that I attended the deceased from <b>4-19-57</b> , 19 <b></b> , to <b>9-6-1957</b> , 19 <b></b> , that I last saw the deceased alive on <b>9-6-1957</b> , 19 <b></b> , and that death occurred at <b>9:30 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frank R. Lewis</b>		ADDRESS (Street, city or town, state) <b>Willards Maryland</b> DATE SIGNED <b>9-7-57</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Frank R. Lewis</b>		<b>Willards, Maryland</b> <b>Sept. 7 / 57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept. 8, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsonsburg, Maryland Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Parsonsburg, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME- SALISBURY, MD.</b>		24a. REC'D BY REGISTRAR <b>Mary H. Holloway</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 9 1957



# CERTIFICATE OF DEATH

BUREAU V. 2

SEP 9 1957

RECEIVED

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10021

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jesterville</b>		c. LENGTH OF STAY IN 1b <b>8 mo.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>At home</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X 2 Jesterville</b>	
3. NAME OF DECEASED (Type or print) <b>John Westley Winder</b>		d. STREET ADDRESS <b>7</b>	
4. DATE OF DEATH Month <b>9</b> Day <b>7</b> Year <b>57</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>O</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-2-1893</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>3</b>	
11. IF UNDER 24 HRS. Hours <b>5</b> Min.		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>	
3. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Melissa Elsey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW 2</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Lelia Winder, 1708 Wharton St., Philad</b>		Address <b>elphia, Pa.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>9-9-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/11/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Jesterville Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Jesterville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. H. Mossie</b>		24a. REC'D BY REGISTRAR <b>SEP 23 1957</b>	
ADDRESS <b>Bivalve, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
SEP 23 1957

BUREAU V. 3

SEP 23 1957

RECEIVED



BUREAU V. 2

SEP 24 1957

RECEIVED